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	0013278	A. BUILDING: _____ B. WING _____	C 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLARTE RESIDENCE	**1171 21ST ST NORTH WISCONSIN RAPIDS, WI 54494**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 03/12/2025 with additional information gathered through 03/21/2025, Surveyor conducted a standard survey, self-report and two complaint investigations at Solarte Residence. As a result 3 deficiencies were identified. Two of two complaints were substantiated. Census: 8	N 000		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 employees reviewed received all required orientation training prior to performing job duties. Resident Assistant I did not have orientation training on emergency and disaster plan and evacuation procedures. Findings include:	N 230		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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N 230	Continued From page 1 The facility was licensed to provide care and services to residents within the client groups of traumatic brain injury, developmentally disabled and emotionally disturbed and/or have mental illness. On 03/13/2025, Surveyor conducted a review of 2 employee records to verify compliance with all employee orientation training requirements. Surveyor requested training records for Resident Assistant I. On 03/13/2025 at 2:00 PM, Surveyor reviewed the employee record for Resident Assistant I. Resident Assistant I was hired on 12/26/2024 and the record did not contain evidence of orientation training on emergency and disaster plan and evacuation procedures. On 03/13/20205 and 03/18/2025, Surveyor sent emails to Director of Resident Services F indicating Resident Assistant I's record was missing evidence on the above orientation training topic. On 03/18/2025 at approximately 2:00 PM, Surveyor interviewed Director of Resident Services F regarding the above missing documentation for Resident Assistant I. Director of Resident Services F indicated Former House Supervisor E was terminated on 03/10/2025 and s/he was unsure where Former House Supervisor E stored all the documents and files. Director of Resident Services F stated s/he could not locate the requested information, but would continue to look. On 03/18/2025 at 3:03 PM, Director of Resident Services F sent the following email to Surveyor,	N 230		

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N 230	Continued From page 2 "The document is missing."	N 230		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure Resident 1 received all prescribed medications in the dosages and at intervals prescribed by the practitioner. Resident 1 did not receive his/her prescribed Clonidine during the AM medication pass on 03/10/2025 as the medication remained in the bubble pack card, even though the medication pass was charted as given. This is a repeat deficiency. See SOD 3JXW11, dated 10/08/2019. Findings include: On 02/11/2025 and 03/21/2025, the Department received concerns regarding medication administration. On 03/12/2025 at 11:30 AM, Surveyor observed the medication cart with Shift Supervisor A. Shift Supervisor A explained medications were dispensed by correlating the date with the	N 352		

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matching number on the bubble pack card. After the medication is punched out and administered, staff initial and date the back of the card. Surveyor observed Resident 1's AM Clonidine bubble pack card and noticed an extra dose remained in the card. Surveyor then flipped the card over and observed the dates and staff initials on the card. There was no documentation the dose was given on 03/10/2025. Shift Supervisor A acknowledged the observation and verified Resident 1's AM Clonidine medication was not given on 03/10/2025. Shift Supervisor A then used the facility's electronic medication administration record, ECP, to verify the charting. Shift Supervisor A found the 03/10/2025 medication which remained in the bubble pack was documented as being administered on 03/10/2025 at 7:00 AM.

On 03/17/2025, Surveyor reviewed Resident 1's record which indicated, the resident was admitted to the facility on 05/01/2018 with diagnosis to include autistic disorder, seizures and severe cognitive disorder. Additionally, the facility managed and administered all of Resident 1's medication.

A physician's order dated 01/30/2025 for Resident 1 indicated, "Clonidine HCL 0.1 mg (milligram) tablet Oral (by mouth). Take 1 tablet by mouth at 7 AM...[anxiety]"

An incident report for Resident 1 dated 03/12/2025 indicated, "A state surveyor was doing a medication cart audit and discovered a missed medication. [Resident 1] did not receive [her/his] 8 AM dose of Clonidine HCL 0.1 mg on 03/10/2025...Physician and Representative notified."

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N 352	Continued From page 4 On 03/12/2025 at 11:35 AM, Surveyor discussed the above observation of Resident 1's medication being documented as being administered but remaining in the bubble pack with House Supervisor B. House Supervisor B acknowledged Surveyor's observation and stated the facility utilizes a buddy check system to track and correct issues but was unsure if this was completed on 03/10/2025.	N 352		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure all residents were safeguarded from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the residents because of the residents' conditions or disabilities. On 03/10/2025, Resident 2 was being transported in a motor vehicle by Resident Assistant C. During transport Resident Assistant C and Resident 2 were involved in a collision. Following the incident Resident Assistant C was tested for	N 358		

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alcohol/drugs and found to be positive for Marijuana (THC). Additionally, Resident Assistant C was not an eligible driver per facility policy. As a result of the collision, Resident 2 sustained bilateral bruising to her/his shins.

On 03/06/2025, staff did not provide safe wheelchair transportation for Resident 3. Resident 3 was propelled out of his/her wheelchair due to the wheelchair wheels getting stuck on the bottom of the ramp. Resident 3 suffered a fall outside and required the assistance of non-emergency personnel to assist the resident back into his/her wheelchair. During the Surveyor's visit on 03/12/2025, 3 of 3 ramps were not maintained in good repair and free of hazards. Additionally, the floor surface near the exit door in the dining area was buckling and in need of repair, creating a potential trip hazard.

The facility received a license on 04/01/2011 as a Class CNA (non-ambulatory) facility which serves residents who are ambulatory, non-ambulatory, or semi-ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting. The facility is licensed to care for 8 residents with programming for residents including traumatic brain injury, developmentally disabled and emotionally disturbed and/or have mental illness. At the time of survey there were eight residents who lived in the home, all eight residents either used a wheelchair for mobility or needed assistance with mobility.

Findings include:

RESIDENT 2

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A facility self-report dated 03/10/2025 indicated, "On 03/10/2025 at 9:01 AM, [Resident Assistant C] buckled [Resident 2] into the passenger side back seat and ensured [her/his] walker was securely placed in the trunk before departing to the day program. One block away from leaving the facility, the vehicle was struck by another car that ran a yield sign. The impact deployed the airbags. Staff promptly called 911 and informed management...EMS (Emergency Medical Services) determined there were no injuries or complications sustained by either the staff or the resident. [Resident 2] refused treatment twice, staff was prompted to sign the refusal of treatment form for [Resident 2]. [Resident Assistant C] went to urgent care to follow up after the incident. The facility vehicle was towed... [Resident 2] returned to the facility where [s/he] is being monitored by staff."

On 03/12/2025 at approximately 12:05 PM, Surveyor attempted to interview Resident 2 while s/he was sitting at a table in POD B. Surveyor noted Resident 2 was difficult to understand. Resident 2 showed Surveyor her/his legs by lifting her/his pant legs. Surveyor observed bilateral bruising to Resident 2's shins. Shift Supervisor A verified the bruising on Resident 2's shins were from the motor vehicle accident on 03/10/2025. Shift Supervisor A stated, "[Resident 2] has been complaining of some back pain after the accident, but has been refusing medical treatment."

On 03/17/2025, Surveyor reviewed Resident 2's record which indicated, the resident was admitted to the facility on 12/07/2022 with diagnosis to include schizoaffective disorder, epilepsy and hearing loss. Resident 2's ISP (Individualized Service Plan) dated 01/07/2025 indicated, Resident 2 ambulated independently and required

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monitoring and/or assistance with all ADL's (Activities of Daily Living). Additionally, the ISP stated, "[Resident 2] had been identified as a fall risk. Ensure path is free of hazards...Transportation: Staff is responsible for transporting [Resident 2] to and from appointments and outings."

On 03/19/2025, Surveyor reviewed a "Skin/Body Observation" form for Resident 2. The form was dated 03/11/2025 and indicated Resident 2 had bruises to her/his right and left leg and to the back of the resident's right and left hand.

On 03/18/2025, Surveyor reviewed Resident 2's observations notes from 03/10/2025-03/17/2025 and the following was noted:
~03/11/2025 at 4:30 AM- ..."[Resident 2] was also telling writer [s/he] can't walk, my legs really hurt..."
~03/13/2025 at 6:00 AM- ..."Staff continue to monitor [her/his] bruises..."
~03/17/2025 at 6:45 AM- ..."[Resident 2] still complains of back pain."

On 03/17/2025, Surveyor reviewed Resident Assistant C's personnel file. The following was noted:

~A "Termination Form" dated 03/10/2025 indicating, "On the morning of 03/10/2025, [Resident Assistant C] was involved in a vehicle accident while a member was in the company vehicle. Management sent [Resident Assistant C] for a Post Accident Drug Screening per Browns Living policy 4.15 Drug and Alcohol Policy. [Resident Assistant C's] screening tests came back positive for THC...Corrective action: Immediate termination of the employment relationship. The above-mentioned statement is

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enough to warrant immediate termination to protect the company and members from undue risk..."

~A "Onsite Custody and Control/Result" form for Resident Assistant C dated 03/10/2025 indicated, Resident Assistant C tested positive for THC.

On 03/12/2025 at 9:30 AM, Surveyor spoke with HRD (Human Resource Director)-D. HRD-D indicated Resident Assistant C was terminated due to the motor vehicle accident involving Resident 2 on 03/10/2025. HRD-D stated, "[Resident Assistant C] was driving [Resident 2] to work in the facility van and was involved in a vehicle accident. [Resident Assistant C] was not an eligible driver per our policy." HRD-D went on to say, "[Former House Supervisor E] was also terminated for allowing [Resident Assistant C] to drive [Resident 2] to work when [Former House Supervisor E] was aware [Resident Assistant C] was not an eligible driver."

On 03/17/2025, Surveyor reviewed a "Termination Form" for Former House Supervisor E dated 03/10/2025 indicating, "On the morning of 03/10/2025, [Former House Supervisor E] assigned an employee to drive a member to their job knowing that this employee was NOT an eligible driver. [Former House Supervisor E] admitted to [Director of Resident Services F], [s/he] was aware the employee was not an eligible driver but tasked [her/him] with driving because [s/he] was "busy" and because of the "lack of eligible drivers." This non-eligible driver was involved in a car accident on 03/10/2025...Corrective action: Immediate termination of the employment relationship. The above-mentioned statements have caused irreparable damage, financial hardship, and are

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egregious enough to warrant immediate termination to protect the company and members from undue risk..."

On 03/19/2025 at 4:00 PM, Surveyor interviewed Director of Resident Services F regarding the above incident. Director of Resident Services F verified the above incident occurred and both Resident Assistant C and Former House Supervisor E were terminated. Director of Resident Services F stated, "I did a skin/body check on [Resident 2] the day after the accident and discovered bruising to [her/his] lower legs and hands. [Resident 2] would not let me check [her/his] whole body."

Resident 3

On 03/12/2025 at approximately 10:00 AM during a tour of the home, Resident 3 informed Surveyor s/he flipped out of his/her wheelchair recently when staff pushed him/her up the ramp. Resident 3 stated, "The ramps around here could use some work...I flipped out of my wheelchair last week because my wheels got caught on the front ramp...The ambulance and fire department had to come and get me back into my chair...No, I didn't get hurt."

On 03/17/2025, Surveyor reviewed Resident 3's record which indicated, the resident was admitted to the facility on 02/28/2025 with diagnosis to include diabetes, muscle weakness and absence of left leg below the knee. Shift Supervisor A indicated Resident 3 utilized a wheelchair for ambulation and a mechanical lift for all transfers.

An incident report for Resident 3 dated 03/06/2025 indicated, "On 03/06/2025 at 11:28 AM, [Resident 3] was being wheeled up the

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driveway and inside of the house by the Floor Supervisor. When attempting to wheel [Resident 3] up the wheelchair ramp, the front two wheels did not lift off the ground and got stuck on the bottom of the wheelchair ramp. Snowy and icy conditions could be a factor. The two front wheels were stuck as [Resident 3's] wheelchair started tipping forward. The momentum caused [him/her] to fall out of [his/her] wheelchair... [Resident 3] fell headfirst but was able to put [his/her] arms down in front of [him/her] to break [his/her] fall. [Resident 3] landed on [his/her] left side at the bottom of the wheelchair ramp...Staff assessed the situation and determined a mechanical lift would not be feasible as the incident took place outside, on a slanted wheelchair ramp, and in snowy/icy conditions. Staff contacted non-emergency at 11:28 AM for assistance with transferring [Resident 3]. Staff brought out pillows and blankets to try and make [Resident 3] as comfortable as possible while waiting for non-emergency to arrive. Non-emergency arrived at the facility at 11:38 AM." The report indicated Resident 3 did not sustain any injuries.

On 03/12/2025, Surveyor toured the facility and observed a total of 4 exits. Three of the 4 exits where ramped to grade (two ramps were located in the back and one ramp was located in the front). All three ramps were wooden ramps with handrails on each side. Surveyor observed all 3 ramps and noted they were not maintained in good repair and free of hazards. Observations included the following:
~The back ramp exiting POD A had 2 loose boards near the bottom of the ramp that were not secure
~The back ramp exiting POD B had a board near the bottom of the ramp that had dropped

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N 358	Continued From page 11 approximately an inch creating an uneven surface ~The front ramp had a board at the bottom of the ramp that was warped and lifting away from the ground During the tour on 03/12/2025, Surveyor also noted buckling and raised vinyl plank flooring (approximately 3 feet long) in POD A dining area, creating a potential trip hazard. On 03/12/2025 at 10:30 AM, House Supervisor B and Maintenance G acknowledged all the exterior ramps were in need of repair. Maintenance G informed Surveyor the facility has been aware the exterior ramps were in need of repair and stated, "The ramps were put down as a capital project plan a while ago, but I haven't been made aware of when the ramps will be fixed." Maintenance G then stated, "The back ramp exiting POD B is sinking down and definitely is a trip hazard." When Surveyor asked about the flooring in POD A dining area, Maintenance G stated, "A work order for the flooring was submitted on 06/05/2024, but it hasn't been addressed."	N 358		